

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6645

CERTIFICATE OF DEATH

06639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Plum Point</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>County Hosp.</i>		d. STREET ADDRESS <i>Prince Frederick</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Maggie</i>	Middle <i>Boyer</i>	Last 4. DATE OF DEATH Month Year <i>6 - 9, 1958</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 2</i>		
9. AGE (In years last birthday) <i>93 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
13. FATHER'S NAME <i>Jacob Broom</i>	14. MOTHER'S MAIDEN NAME <i>Cornelia Boston</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>9040</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marion Harrod, Plum Point</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>FRACTURED HIPS (Fracture</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Practical Pneumonia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>May 9</i> 1958 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Plum Pt. Calvert Md.</i>	(County) <i>Calvert</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May 10</i> , 19 <i>58</i> , to <i>May 10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 10</i> , 19 <i>58</i> , and that death occurred at <i>Plum Pt. Calvert Md.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Maggie C. Jett</i>	M.D.	ADDRESS (Street, city or town, state) <i>Prince Frederick Md.</i>			DATE SIGNED <i>6/1/58</i>
PHYSICIAN'S NAME (Type) <i>Maggie C. Jett</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-12-58</i>	22b. DATE THEREOF <i>5-12-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Edmunds</i>	22d. LOCATION (City, town, or county) <i>Sundland</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.E. Sewell, Prince Fred. Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 17 '58	24b. REGISTRAR'S SIGNATURE <i>Alt. Search</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646 CERTIFICATE OF DEATH

Reg. Dist. No.

06640

1. PLACE OF DEATH o. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince George's life</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Calvert County Hospital</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown, Md.</i>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <i>Leroy G. Brown</i>		4. DATE OF DEATH Month <i>6</i> Day <i>10</i> Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>col.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. B. DATE OF BIRTH <i>1902</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) <i>56 yrs.</i>		10. IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. Months <i>6</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick mason</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brick Mason</i>	
11. BIRTHPLACE (State or foreign country) <i>Marion, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>X.S.A.</i>	
13. FATHER'S NAME <i>Barrett</i>		14. MOTHER'S MAIDEN NAME <i>Ella Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>442X</i>		16. SOCIAL SECURITY NO. <i>Mr. Pauline V. Brown -</i>	
17. INFORMANT <i>Address Huntington, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Cardio vascular cerebral disease 3 yrs</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Acute debility of heart</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Plum Point</i> (County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>May 1, 1958</i> to <i>May 1, 1958</i> , that I last saw the deceased alive on <i>May 1, 1958</i> , and that death occurred at <i>9:34 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Huntingtown, Md.</i> DATE SIGNED <i>May 6/12/58</i>	
ACTUAL SIGNATURE <i>H.W. Ward</i>		PHYSICIAN'S NAME (Type) <i>H.W. Ward</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/13/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Plum Point Church Plum Point, Md.</i>		22d. LOCATION (City, town, or county) <i>(State) Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>LeRoy G. Berry</i>		ADDRESS <i>Huntingtown, Md.</i>		24a. REC'D BY REGISTRAR <i>Reg. Dist. No. 06640</i>		24b. REGISTRAR'S SIGNATURE <i>LeRoy G. Berry</i>	
VS A15 (4) 15M 9/55		DATE <i>JUN 16 '58</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6647

CERTIFICATE OF DEATH

06641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Lenzer	Middle Benjamin	Last Cox	4. DATE OF DEATH June 18 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH October 12, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Walter Cox			14. MOTHER'S MAIDEN NAME Susan P. Hardesty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I 217-36-6988		17. INFORMANT Mrs Lenzer Cox Huntingtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary Occlusion</i> INTERVAL BETWEEN DUE TO <i>about</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <i>Coronary Artery Disease</i> 46 hours (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-16, 1958</i> to <i>6-18, 1958</i> that I last saw the deceased alive on <i>June 18, 1958</i> , and that death occurred at <i>8:10 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>PAGE C. JETT</i> ADDRESS (Street, city or town, state) <i>Powell Frederick 6/20/58</i> DATE SIGNED PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-21-58		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Harmony	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. H. Hutchins</i>			ADDRESS <i>Owings</i>		24a. REC'D BY REGISTRAR DATE JUN 24 '58
					24b. REGISTRAR'S SIGNATURE <i>Albion</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		6648 <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		b. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>4 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY <i>Calvert</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>James</i>	Middle <i>Edward</i>	Last <i>Sutton</i>	4. DATE OF DEATH <i>Oct 17, 69</i>	Month <i>Oct</i>	Day <i>5</i>	Year <i>1958</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 17, 69</i>	9. AGE (in years, months and days) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. END OF BUSINESS OR INDUSTRY <i>Waterman Fisher</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mr. Belle Robinson, Husband</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Old Ostomy</i>		
						INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been in bed a year</i>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			
					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
					20f. (City or town) <i></i>		(County) <i></i> (State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>6/5/58</i>			
EXAMINER'S NAME (Type) <i>H. W. WARD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 7, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Plym. Holiness Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		
						(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Funeral, Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred L. Lewis</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6649

CERTIFICATE OF DEATH

Reg. Dist. No.

06643

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Newborn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS 702 S. Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Female Infant	Middle Griffith	Lost	4. DATE OF DEATH June	Month 22 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1958	9. AGE (In years lost birthday) Newborn	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 30 Hours 5 Min 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Donald Griffith		14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 776 X		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mother 702 S. Fayette St., Alex., Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Prematurity					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1958 , to June 22, 1958 , that I last saw the deceased alive on June 22, 1958 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Roberto de Villarreal</i> M.D.				ADDRESS (Street, city or town, state) <i>St. Leonards, Maryland</i> DATE SIGNED <i>June 23/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58		22c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill	
22d. LOCATION (City, town, or county) Alexandria				(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Beverly Montalto</i>		ADDRESS P. O. Box 65		24a. REC'D BY REGISTRAR DATE 26 '58	
Cunningham Funeral Home, Inc. Alexandria, Va.				24b. REGISTRAR'S SIGNATURE <i>Albert Edward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

625

MAY 2001

DEATH CERTIFICATE

NAME

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6650

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>		c. LENGTH OF STAY IN 1b <i>Life</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Carrie A. Grover</i>		4. DATE OF DEATH Month <i>6</i> Day <i>16</i> Year <i>1958</i>				
5. SEX <i>W</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 3, 1889</i>			
9. AGE (In years last birthday) <i>68 yrs.</i>	10. IF UNDER 1 YEAR <i>6 months</i>	11. IF UNDER 24 HRS. <i>13 days</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>				
13. FATHER'S NAME <i>James A. Webster</i>	14. MOTHER'S MAIDEN NAME <i>Alice M. Thomas</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Calvert W. Grover, Lusby, Md.</i>	Address <i>—</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular cerebral disease</i>						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i>						
DUE TO (c) <i>—</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found dead in my car at a table</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>87</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i> DATE SIGNED <i>6/16/58</i>						
ACTUAL SIGNATURE <i>H. W. Ward</i>		PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 19, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's Cemetery</i>	22d. LOCATION (City, town, or county) <i>Lusby - Calvert Co - Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Warkness & Son - Mutual, Md.</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>—</i>	24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>	
VS A15 (4) 15M 9/55		DATE <i>JUN 18 '58</i>		DATE <i>—</i>		

31-2800014-5114-010 TRANSAKSHITI GRAYGRAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06645

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>C. EVERETT HALL</i>		First	Middle
4. DATE OF DEATH <i>June 25 1958</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 14, 1894</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years lost birthday) <i>63 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles E. Hall</i>		14. MOTHER'S MAIDEN NAME <i>Estelle Bowen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>218-12-7035</i>	
17. INFORMANT <i>Mrs. Everett Hall - Barstow, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/25/58</i> to <i>6/25/58</i> , that I last saw the deceased alive on <i>6/25/58</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Page C. Jett</i> M.D. <i>Prince Frederick 6/25/58</i> DATE SIGNED <i>6/25/58</i> PHYSICIAN'S NAME (Type) <i>Page C. Jett</i> PRINCE FREDERICK 110			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 28, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Ashley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Barstow, Calvert, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Starkness & Son - Mutual, Md.</i>		24a. ADDRESS ADDRESS	
		24b. REC'D BY REGISTRAR DATE 1 '58	
		24c. REGISTRAR'S SIGNATURE <i>Al Heenrich</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06646

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If non-in hospital, give street address)

Calvert Co

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
6

Day
3

Year
1958

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

9. AGE (in years
to nearest day)

Feb. 13,

99 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sinkley Harper

14. MOTHER'S MAIDEN NAME

Mary Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

442 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cardio vascular renal disease

INTERVAL BETWEEN
ONSET AND DEATH

Hypertension - Hemiplegia

6 hrs

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

B.P. 260/158

20c. TIME OF INJURY Month, Day, Year

10/5 a. m.

6/3 1958

20d. INJURY OCCURRED

While
at work

Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Prince George's Co.

20f. (City or town)

Calvert Md

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H.W. Ward

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6/3/58

22a. BURIAL OR CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

6-7-58

House of Prayer

Prince Geo. Co. Md

WEEHAWKEN EXAMINER'S CERTIFICATE OF DEATH

1900

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6653

CERTIFICATE OF DEATH

Reg. Dist. No. 06647

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Island</i>				
3. NAME OF DECEASED (Type or print)		First <i>ROBERT</i>	Middle <i>FRANKLIN</i>			
4. DATE OF DEATH Month <i>June</i>		Day <i>27</i>	Year <i>1958</i>			
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Apr. 9, 1898</i>			
9. AGE (in years lost birthday) <i>60 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fishing & Oystering</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waterman</i>				
11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>William J. Horsmon</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Horsmon</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-03-8000</i>				
17. INFORMANT <i>Mrs Carlene Horsmon - Lusby, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure -</i>				
DUE TO <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		(b) <i></i>				
DUE TO <i></i>		(c) <i>Arterio sclerotic heart disease</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i>9/27/58</i>				
ACTUAL SIGNATURE <i>R. E. V. CARRERE</i>		PHYSICIAN'S NAME (Type) <i>R. E. V. CARRERE</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Island Cem</i>	22d. LOCATION (City, town, or county) <i>Baltimore Island Calvert Co., Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Harkness & Son - Mutual, Md.</i>		24a. ADDRESS <i></i>	24b. REC'D BY REGISTRAR DATE <i>JUL 1 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Albert J. Deneau</i>		

81-20001-48-10311C12M1819 STATE 09141784M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar, or for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06648

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert County Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i>	
3. NAME OF -DECEASED (Type or print) <i>Ronald Francis Jacobs</i>		d. STREET ADDRESS <i>3407 - 37th St. Colmar Manor</i>	
4. DATE OF DEATH <i>June 14 1958</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>11/11/33</i>	
9. AGE (In years at death <i>24 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pa.</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank W Jacobs</i>		14. MOTHER'S MAIDEN NAME <i>Mary L. Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>None</i>		16. SOCIAL SECURITY NO. <i>577-42-1472</i>	
17. INFORMANT <i>W. Jacobs</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury of chest fracture of spine</i> DUE TO <i>823X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Auto accident.</i> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>auto hit tree</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>7:30 a.m. 6/12 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>road</i>	
20f. (City or town) <i>Parsons</i>		(County) <i>Cal.</i>	
(State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>14 June 58</i>	
ACTUAL SIGNATURE <i>G. J. Weems</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>G. J. Weems</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/18/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. John's Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pittston, Pa.</i>	
(State) <i>Pa.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home</i>		ADDRESS <i>1st Rainier St. N.W.</i>	
24a. REC'D BY REGISTRAR DATE JUN 19 '58		24b. REGISTRAR'S SIGNATURE <i>Albion</i>	

WATERWAY STATE OF HENRY COUNTY, IOWA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be given as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

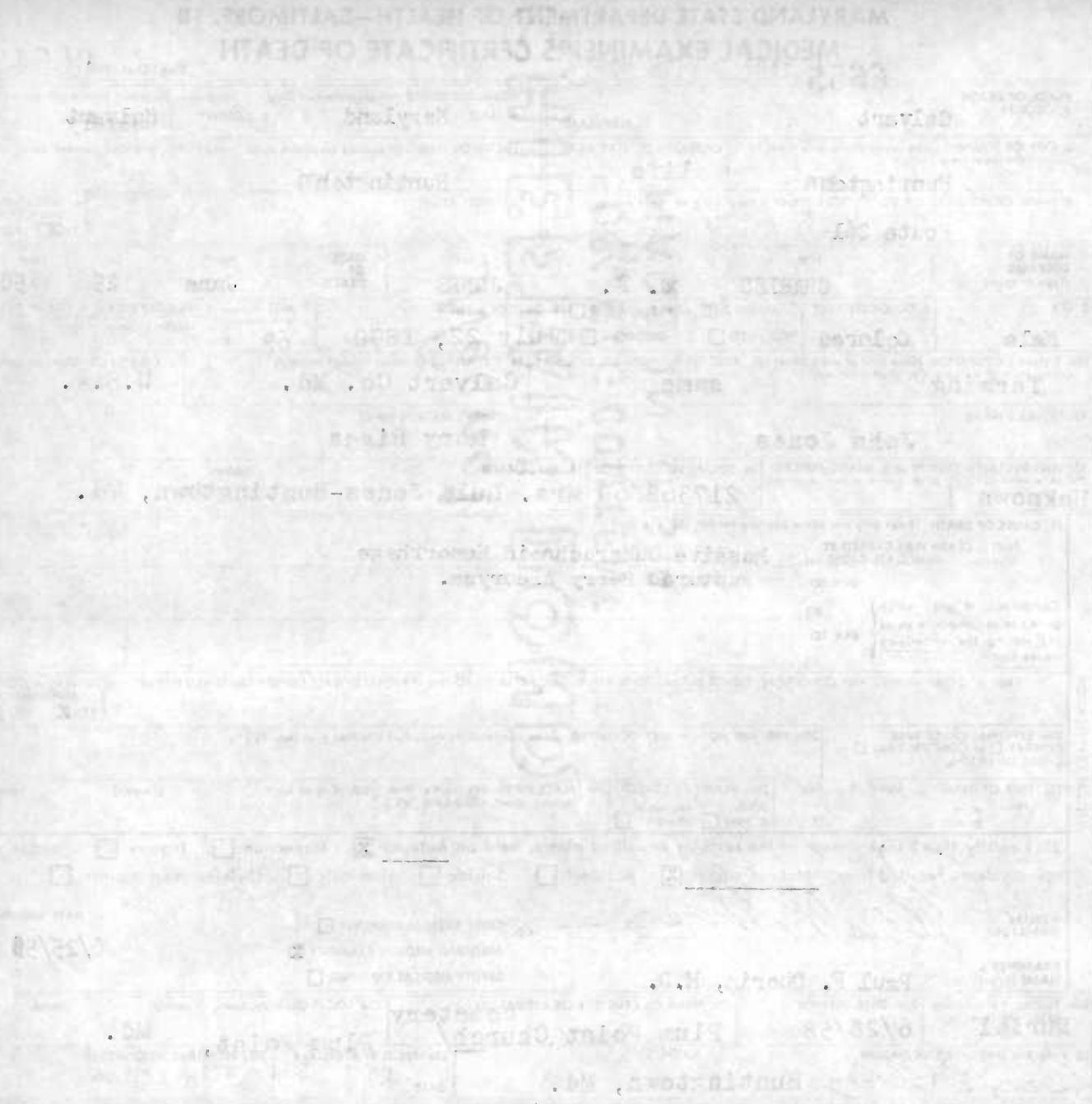
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6655

Item 7 Film G231 7/18/58 pg. 3

Reg. Dist. No 06649

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 261 Hwy 263		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown	
d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First S. F.	Middle JONES
4. DATE OF DEATH June 25 1958		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1890	
9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY same	
11. BIRTHPLACE (State or foreign country) Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Mary Riggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 217368869 17. INFORMANT Mrs. Lula Jones-Huntingtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330 X DUE TO Massive Subarachnoid Hemorrhage Ruptured Berry Aneurysm.		Address	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 6/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58	
22c. NAME OF CEMETERY OR CREMATORIUM Plum Point Church		22d. LOCATION (City, town, or county) Cemetery Plum Point Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Freoy E. Berry</i>		ADDRESS Huntingtown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE <i>West couch</i>	
VS. A15ME 5M 2/57			



~~TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral-director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.~~
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial/transit or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06656

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Calvert</i> MARYLAND		a. STATE <i>Calvert</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown Md</i>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Albert John Lankard</i>		First <i>Albert</i>	Middle <i>John</i>
		Last <i>Lankard</i>	DATE OF DEATH <i>6 30 1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct 1 1883</i>
9. AGE (In years last birthday) <i>74</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done) <i>Hospital Refuse</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Albert John Lankard</i>		14. MOTHER'S MAIDEN NAME <i>Catharine Dauernheim</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Wife</i>		Address <i>1000 Highland Avenue</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO <i>Cardiac Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Causes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 min</i>	
b) <i>Cardiac Arrest</i> DUE TO <i>Arrest at 8:40 PM</i>		8 yrs	
c) <i>Found Dead in Bathroom</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>6/30/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>7/19/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Crematory</i>		22d. LOCATION (City, town, or county) <i>Pr. Geo. Co., Maryland</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>Jul 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Beach</i>	

87. FEDERAL BUREAU OF INVESTIGATION - U. S. DEPARTMENT OF JUSTICE
WASHINGON, D. C.

SEARCHED

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2

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6657

CERTIFICATE OF DEATH

06651

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sunderland

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. STATE

Md

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Sunderland Md

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

6

4

1958

5. SEX

F

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 6,

9. AGE (In years
lost birthday)

96 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Jones

14. MOTHER'S MAIDEN NAME

Anelia Tasker

Address

Florence Johnson Sunderland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

442 X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.(b)
DUE TO
(c)INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2-10, 1958, to 4-4-1958, that I last saw the deceased alive on 6-03-1958, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

Huntingtown, Md.

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

6-8, 58

22c. NAME OF CEMETERY OR CREMATORI

Mt. Hope

22d. LOCATION (City, town, or county)

Sunderland

(State)

md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

PE Sewell, Prince Fred, Md

24a. REC'D BY REGISTRAR

DATE JUN 10 '58

24b. REGISTRAR'S SIGNATURE

W. Leach

CERTIFICATE OF DEATH

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

1900-1901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06652

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>O. Beach</i>	c. LENGTH OF STAY IN 1b	3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>		d. STREET ADDRESS <i>720 E. N.E.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>David Laver Munos</i>	First	Middle	Last
4. DATE OF DEATH <i>Nov. 9-1918</i>	Month	Day	Year <i>9 1918</i>
5. SEX <i>M</i>	6. COLOR OR FACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 9-1918</i>
9. AGE (In years last birthday) <i>39 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agriculture Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Gov.</i>	
11. BIRTHPLACE (State or foreign country) <i>Taylor Spring Ill. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Sebastian Munos.</i>		14. MOTHER'S MARRIED NAME <i>Mary Munos</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes. 1931-1945</i>		16. SOCIAL SECURITY NO. <i>720-6-1196</i>	
17. INFORMANT <i>Cardiac failure</i>		Address <i>720 E St. N.E Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Swimming</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been swimming came ashore and died</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Had been swimming</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Calvert Md</i>	
20c. TIME OF INJURY Hour <i>6</i> p.m. <i>58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <i>O. Beach Ches Bay Calvert Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Wind</i>		DATE SIGNED <i>Owny Mc</i>	
EXAMINER'S NAME (Type) <i>—</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/12/58</i>		22b. DATE THEREOF <i>6/12/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St Agnes Cem.</i>		22d. LOCATION (City, town, or county) <i>Hillsboro, Ill.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons</i>		ADDRESS <i>300 4th St. N.E.</i>	
24a. REC'D BY REGISTRAR <i>11 58</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burton</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
3. NAME OF DECEASED (Type or print) <i>Gray</i>		First <i>William</i>	Middle <i>Steffey</i>
4. DATE OF DEATH Last <i>8</i>		Month <i>8</i>	Day <i>26</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Sept 24 1914</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <i>43</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Cochran</i>		14. MOTHER'S MAIDEN NAME <i>Frances Frolee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>House Steffey Burton</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tuberculosis</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i>			
DUE TO (c) <i>Died at 1030 Ave</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Has been sick over a year</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Prince Frederick Md.</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>6/26/58</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-26-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St Pauls</i>		22d. LOCATION (City, town, or county) <i>Prince Frederick Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. D. Hutchins</i>		ADDRESS <i>Owings Md.</i>	
24a. REC'D BY REGISTRAR <i>—</i>		DATE <i>JUL 1 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>			

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>2nd</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burke</i>	
3. NAME OF DECEASED (Type or print) <i>Ray Jerry</i>		d. STREET ADDRESS <i>STINNETT</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 27, 1916</i>
9. AGE (in years lost, birthday) <i>42</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Year <i>1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
10c. BIRTHPLACE (State or foreign country) <i>Charles County, Md</i>		10d. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Stinnett</i>		14. MOTHER'S MAIDEN NAME <i>Mothie Dowsley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-12-478</i>	
17. INFORMANT <i>Ruth Minter-Solomons, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause, (b), stating the under- lying cause lost. <i>BRONCHIAL ASTHMA + Emphysema</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 10, 1958</i> , to <i>June 9, 1958</i> , that I last saw the deceased alive on <i>June 8, 1958</i> , and that death occurred at <i>4 p. m.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Page E. Jett</i>		ADDRESS (Street, city or town, state) <i>Prince Frederick, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 12, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince Frederick, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md</i>		24a. REC'D BY REGISTRAR DATE JUN 12 '58	
24b. REGISTRAR'S SIGNATURE <i>Asst. Reg. 1</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06655

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute by certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Calvert</i> MARYLAND		a. STATE <i>Florida</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Prince Frederick</i>		<i>Cavon Park</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
		<i>48x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Frank</i>	Middle <i>A</i> Last <i>Truman</i>
4. DATE OF DEATH		Month <i>6</i>	Day <i>12</i> Year <i>1958</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept 23 1870</i>		9. AGE (In years <i>87</i> last birthday) yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Candler S. B. Road</i>	11. BIRTHPLACE (State or foreign country) <i>Irene</i>
12. CITIZEN OF THAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Augustus J. Truman</i>	
14. MOTHER'S MAIDEN NAME <i>Eliza Buffa</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>704-18-1536</i>		17. INFORMANT <i>John B. Gray</i>	Address <i>Prince Jules</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i>		5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cadis Venular Reanal Dism</i>			
DUE TO (c) <i>Cadis failure</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found dead in bedroom</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>Owings</i> 6/12/58	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>June 14, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>16 '58</i>
		DATE	24b. REGISTRAR'S SIGNATURE <i>W. E. Lewis</i>

